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ON

Impact Assessment of Pradhan Mantri Jan Arogya Yojana In Bihar: A case study of Sitamarhi District.

(Faculty of Social Science, LNMU, Darbhanga)

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Title of the Research:-

Impact Assessment of Pradhan Mantri Jan Arogya Yojana In Bihar : A case study of Sitamarhi District

1. Introduction :-

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY) of the Government of India is a national health insurance scheme that aims to provide free access to healthcare for low income groups in the country. Roughly, the bottom 50% of the population of India qualifies for this scheme. People using the program access their own primary care services from a family doctor. When anyone needs additional care, then PM-JAY provides free secondary health care for those needing specialist treatments and tertiary health care. The programme is part of the Indian government's National Health Policy. It was launched in September 2018 by the Ministry of Health and Family Welfare. The ministry later established the National Health Authority (NHA) as an organization to administer the program. It is a centrally sponsored scheme and is jointly funded by both the federal and state governments. By offering services to 50 crore (500 million) people it is the world's largest government sponsored healthcare program.

In 2017, an Indian version of the Global Burden of Disease Study reported major diseases and risk factors from 1990 to 2016 for every state in India. This study brought a lot of interest in the government's health policy because it identified major health challenges which the government could address. In 2018, the Indian government described that every year, more than six crores Indians were pushed into poverty because of out of pocket medical expenses. Despite various available regional and national programs for healthcare in India, there was much more to be done. The Indian government first announced the PMJAY as a universal health care plan in February 2018 in the Union Budget of India. The Union Council of Ministers approved it in March in the same year. In June 2018 the applications opened for hospitals through an "empanelment process". In July 2018, the Ayushman Bharat Yojana recommended that people access benefits through Aadhaar but also said that there was a process for people to access without that identity card. PM-JAY was first launched on 23 September 2018 at Ranchi, Jharkhand. By 26 December 2020 the scheme was extended to the Union Territories of Jammu Kashmir and Ladakh. The program has been called "ambitious".

India's 28 states and 8 union territories each make their own choice about whether to participate in PMJAY. In February 2018 when the program was announced 20 states committed to join. In September 2018 shortly after launch some states and territories declined to participate in the program. Maharashtra and Tamil Nadu initially declined to join because they

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each had their own state healthcare programmes. These states later both joined Ayushman Bharat Yojana with special exceptions to make it part of their existing infrastructure. In a similar way, Kerala, despite having its own health program agreed to begin using Ayushman Bharat Yogana from November 2019. West Bengal initially joined the program but then opted out in favor of establishing their own regional health programme. Telangana did the same. By January 2020 Odisha had not joined the scheme. In March 2020 Delhi announced that it would join the program.

In May 2020 Prime Minister Narendra Modi said in his radio show Mann Ki Baat that the Ayushman Bharat scheme had recently benefited more than one crore people. By May 2020, the scheme had provided more than 1 crore treatments with a value of ₹13,412 crore. The number of public and private hospitals empanelled nationwide stands at 24,432. The Ayushman Bharat Yojana programme announced a special collaboration with the Employees' State Insurance programme in November 2019. From June 2020, the program had entered a pilot to cover 120,000 workers with that insurance at 15 hospitals.

When Ayushman Bharat Yojana began there were questions of how to reconcile its plans with other existing health development recommendations, such as from NITI Aayog. A major challenge of implementing a national health care scheme would be starting with infrastructure in need of development to be part of a modern national system. While Ayushman Bharat Yojana seeks to provide excellent healthcare, India still has some basic healthcare challenges including relatively few doctors, more cases of infectious disease, and a national budget with a comparatively low central government investment in health care. Some of the problems lay outside the Health Ministry such as urban development or transport. While many government hospitals have joined the program, many private corporate hospitals have not. The private hospitals report that they would be unable to offer their special services at the government low price, even with a government subsidy. The scheme has faced challenges in form of fraudulent bills. In response, National Health Authority has revoked empanelment of 171 hospitals and imposed a penalty of ₹4.6 crore, another 390 hospitals have been issued show cause notice.

There have been media reports of misuse of the Ayushman Bharat scheme by unscrupulous private hospitals through submission of fake medical bills. Under the Scheme, surgeries have been claimed to be performed on persons who had been discharged long ago and dialysis has been shown as performed at hospitals not having kidney transplant facility. There are at least 697 fake cases in Uttarakhand State alone, where fine of ₹1 crore has been

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imposed on hospitals for frauds under the Scheme. However, unlike the earlier RSBY (Rashtriya Swasthya Bima Yojana) era, plagued by lax monitoring of insurance fraud, AB-PMJAY involves a robust information technology infrastructure overseeing transactions and locating suspicious surges across the country. Health Minister has blacklisted hospitals and named them publicly for misconduct. Initial analysis of high-value claims under PMJAY has revealed that a relatively small number of districts and hospitals account for a high number of these and some hint of an anti-women bias, with male patients getting more coverage. Despite all efforts to curb foul-play, the risk of unscrupulous private entities profiteering from gaming the system is clearly present in AB-PMJAY.

The Bihar State Health Agency has taken a decision to conduct beneficiary audits of all cases amounting to more than Rs 30,000. From September 1, 2019 till August 31, 2020, there were 1,700 such cases. The beneficiary list of the selected cases is sent to the concerned district authority for conduction of the audit. After completion of the beneficiary audit, the audit team sends a detailed report to the State Health Agency. Based on these reports, the State Health Agency has been able to control fraudulent activities to a certain extent. Five hospitals have been suspended till date based upon the reports submitted by the audit team. The exercise also helps the State Health Agency in identifying gaps in services through direct feedback received from beneficiaries during the process of audit. Two dedicated medical teams have been constituted to monitor pre-authorization and claims at the State Health Agency level. Ten cases are identified per day on a random basis and telephonic and desk audit is conducted for the selected cases. Such innovative practices have been an important measure in controlling fraudulent activities in the State.

In Bihar, AB PM-JAY is being implemented under the assurance/trust model. Apart from day-to-day management and administration of the scheme, the State Health Agency also performs specialised tasks such as hospital empanelment, beneficiary identification, claims management, audits, and other related tasks. Therefore, a strong institutional structure was needed at the district level to ensure effective implementation and address operational challenges of such a huge scheme. Consequently, District Implementation Units have been established in most districts of Bihar for effective implementation of the scheme.

2. Review of Literature:-

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A lot of work has been done on various aspects of healthcare Centre in India. The important studies among these works are as follows:

Ashok Pandey (2019) studied that Healthcare has been one of the important elements in the governance system in India since it draws from the principle of welfare state for serving the people. Health has been given prominence in the Sustainable Development Goal (SDG) 3 of the United Nations as well, which ensures healthy lives and well-being to every person. Access to energy is equally important like accessibility to health services for myriad reasons, similarly the SDG 7 mandates the access to reliable, affordable and sustainable energy for improving living standards. From a healthcare perspective, energy is a critical parameter for ensuring universal health care coverage and overall human development, thus 'Health and Energy Integration' is one of promising areas for meeting twin objectives of ensuring energy security to the health institutions and simultaneously enhancing accessibility of health services to the people.

D.S. Pathak (2018) said that the Government of India has several important health initiatives. As a constituents of Union of India, the state of Bihar implements these schemes and programs and similarly many of central schemes such as Aayushman Bharat, NHM (NRHM+ NUHM), Integrated Child Development Scheme, National Program for Control of Blindness, National Leprosy Eradication Program, 'Janni Suraksha Yojna', 'Janni Shishu Suraksha Karykaram' are being implemented in the state for providing arrays of services to the people.

R.N. Tiwari (2015) concluded that the Bihar's expenditure on health stood around Rs. 7318 crore with an annual increase of 20.8%7, however, improving the status of health is still a big challenge. Bihar has consistently underinvested in its healthcare system in the past. It has been ranked at bottom of 36 states and union territories of India on Human Development Index (HDI) ranking-2018. Though, the state has slightly progressed on the score of HDI which was 0.557 2015 and reached to 0.576 in 2018; yet the performance of the state is the lowest among all states and is far lower than the national average, i.e. 0.617.8 As per a report by NITI Ayog, Union health ministry and the World Bank the state was earlier ranked 19th in terms of accessing health services has now slipped to 20th spot in the latest report.

P.K. Roy (2016) said that the health sector challenges in Bihar, like those in other low and middle income countries, are formidable. Public spending on medical, public health, and family welfare in Bihar is much below what is required. Further, the gap between the actual spending and the required amount is larger in the relatively low-income states and this results in marked

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inter-state inequality. The low levels of spending have had an adverse impact on the creation of a preventative health infrastructure. With over 70 percent of the spending on health being out of pocket, the low level of public spending and its uneven distribution have been a major cause of the immiseration of the poor.

This review of literature on health care centre in India reveals that there are many studies on almost all aspects of health care centre in the country. Therefore, the present study is a humble attempt to fill the gap in the existing knowledge on health care centre in India.

3. Significance of the study :-

PM-JAY Providing health coverage for 10 crores households or 50 crores Indians. It also provide a cover of ₹5 lakh per family per year for medical treatment in empaneled hospitals both public and private offering cashless payment and paperless recordkeeping through the hospital or doctor's office; using criteria from the Socio Economic and Caste Census 2011 to determine eligibility for benefits; no restriction on family size, age or gender. All previous medical conditions are covered under the scheme; it covers 3 days of pre-hospitalisation and 15 days of post-hospitalisation including diagnostic care and expenses on medicines. The scheme is portable and a beneficiary can avail medical treatment at any PM-JAY empanelled hospital outside their state and anywhere in the country providing access to free COVID-19 testing. The health outcomes of the states that adopted PM-JAY improved when compared to the states that did not adopt it. Using difference-in-difference computations that control for confounding factors, this chapter shows that states adopting PM-JAY are able to improve their health outcomes. Relative to states that did not implement PM-JAY, states that adopted it experienced greater penetration of health insurance, experienced a reduction in infant and child mortality rates, realized improved access and utilization of family planning services, and greater awareness about HIV/AIDS. While some of these effects stemmed directly from enhanced care enabled by insurance coverage, others represent spill over effects due to the same. Even though only a short time has elapsed since its introduction, the effects that are identified by the Survey underscore the potential of the program to significantly alter the health landscape in the country, especially for the vulnerable sections.

4. Objectives of the study :-

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Proposed research work will be based on the following objectives:

1. To study the progress of PM-JAY with special reference of Bihar and Sitamarhi.
2. To assess levels of awareness among beneficiaries in the study area.
3. To study the socio-economic factors effecting the implementation of PM-JAY.
4. To analyse the supply and demand side issues in the implementation of the scheme.

5. Hypothesis of the study :-

Proposed research work will testify the following Hypothesis:

1. Socio-economic factors do not effect the beneficiaries of PM-JAY in choosing appropriate hospitalisation.
2. Level of awareness of does not vary among different groups of beneficiaries.
3. There is no significant difference among different gender of beneficiaries on account of benefits rendered.
4. The availability of hospitals in nearby areas do not effect significantly in making choices for hospitalisation

6. Area of the study :-

Sitamarhi is one of the districts in the Mithila region of the Indian state of Bihar, India. Dumra is the administrative headquarters of this district. The district is a part of the Tirhut Division and is located along the border of Nepal. According to the 2011 census Sitamarhi district has a population of 3,423,574. This gives it a ranking of 96th in India (out of a total of 640). The district has a population density of 1,491 inhabitants per square kilometre (3,860/sq mi). Its population growth rate over the decade 2001-2011 was 27.47 Percent. Sitamarhi has a sex ratio of 899 females for every 1000 males, and a literacy rate of 53.53 Percent. 5.56 Percent of the population lives in urban areas. Scheduled Castes and Scheduled Tribes make up 11.85 Percent and 0.09 Percent of the population respectively. At the time of the 2011 Census of India, 82.39 Percent of the population in the district spoke Maithili, 12.92 Percent Hindi, 3.49 Percent Urdu as their first language. 1.20 Percent of the population recorded their language as 'Others' under Hindi. The main dialect of the region is the Bajjika dialect of Maithili.

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Sitamarhi has come first in making golden cards under the Prime Minister's very ambitious scheme Ayushman Bharat Scheme. In the financial year 2021-22, cards were issued to 72 thousand 063 people in Sitamarhi district. Muzaffarpur stood second with 47 thousand 694 cards and Patna stood third with 44 thousand 317 cards. The residents of the district have been made aware regarding Ayushman Bharat Pradhan Mantri Jan Arogya Yojana. Ayushman cards of people were made by establishing coordination with local public representatives at the district, block and panchayat level. As a result, maximum number of golden cards were issued in Sitamarhi in the year 2021-22.

In the financial year 2021-22, 2300 people have been treated under this scheme. Of these, 2013 were treated in private hospitals and 287 in government hospitals. Apart from government hospitals in the district, seven private hospitals have been selected for treatment under the scheme. Ayushman card can be made by visiting the Executive Assistant at Panchayat level, Vasudha Common Service Centre, UTI-ITSL Centre. In making the card, Ration card or Prime Minister's letter in the name of the beneficiary family is necessary for family identification and Aadhaar card for personal identification. Special camps were organized in all the gram panchayats of the district to make cards. An awareness campaign was conducted to spread publicity related to the scheme. For awareness, banners and posters have been put up in all the intersections, public places, RTPS counters, block offices and gram panchayats. So that the people of the village can get information about it. Told that this success was achieved after coordination with the district administration and health department officials.

7. Research Methodology :-

The research will be undertaken based on both primary and secondary data. The present study will be descriptive and analytical in nature.

Collection of Data

Data will be collected from National Health Authority of India and its nodal office in the state. The data will also be collected from different hospitals providing PM-Jay facilities in Sitamarhi and also from select users of the schemes in the district.

(a) Primary Data Sources:

Primary data sources will be collected through the Questionnaire from the select beneficiaries of the schemes.

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(b) Secondary Data Sources:

The Secondary sources will based on data from National Health Authority, Books, Journals/magazines, Book Review and articles related to research work.

8. Work Plan :-

Proposed Research work will be completed under following

Chapters:-

Chapter- 1 Introduction

Chapter- 2 Review of Literature

Chapter- 3 Data Sources and Methodology

Chapter- 4 Analysis of PM-JAY in the context of Bihar and Sitamarhi.

Chapter- 5 Analysing Awareness among the beneficiaries regarding PM-JAY.

Chapter- 6 Evaluation of socio-economic factors on implementation of PM-JAY

Chapter- 7 Assessment of the demand and supply side constraints and its effect.

Chapter- 8 Conclusion and Suggestions

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